

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145439	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/06/2009
NAME OF PROVIDER OR SUPPLIER CHAMPAIGN URBANA REG REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 302 WEST BURWASH SAVOY, IL 61874		
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F 520	Continued From page 51 are discussed during the 24 hour report. Review of the twenty-four hour falls report indicates under the heading "Root Cause" entries that includes "attempt self transfer...attempted to walk...attempted to stand by self...toileted self...lost balance standing..." When asked if attempts were made to discover why residents were doing these things the DON stated no. The DON stated, "...if you are looking for that kind of root cause, it is not there or anywhere..." When asked if the Physician was involved in determining the root cause the DON stated, "...we notify the physician when a resident falls..."	F 520			
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1030a) 300.12106) 300.2040b) 300.3240a) Section 300.1030 Medical Emergencies a) The advisory physician or medical advisory committee shall develop policies and procedures to be followed during the various medical emergencies that may occur from time to time in long-term care facilities. These medical emergencies include, but are not limited to, such things as: 1) Pulmonary emergencies (for example, airway obstruction, foreign body aspiration, and acute respiratory distress, failure, or arrest). 2) Cardiac emergencies (for example, ischemic pain, cardiac failure, or cardiac arrest). 3) Traumatic injuries (for example, fractures, burns, and lacerations).	F9999			

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F9999	<p>Continued From page 52</p> <p>4) Toxicologic emergencies (for example, untoward drug reactions and overdoses).</p> <p>5) Other medical emergencies (for example, convulsions and shock).</p> <p>Section 300.1210 General Requirements for Nursing and Personal Care</p> <p>6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.</p> <p>Section 300.2040 Diet Orders</p> <p>b) Physicians shall write a diet order, in the medical record, for each resident indicating whether the resident is to have a general or a therapeutic diet. The diet shall be served as ordered.</p> <p>Section 300.3240 Abuse and Neglect</p> <p>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.</p> <p>Based on observation, interview and record review the facility failed to:</p> <p>A. Ensure that one of eight sampled residents requiring a pureed diet received, and had access to, only pureed food (R44).</p> <p>B. Provide a timely and appropriate response to an emergency situation, when R44 was found unresponsive in the dining room, with solid food</p>	F9999			

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F9999	<p>Continued From page 53 protruding from his mouth and without respiration or pulse.</p> <p>This resulted in R44 experiencing an anoxic brain injury, due to airway obstruction and food bolus aspiration, ultimately causing his death.</p> <p>Findings include:</p> <p>The Physicians Order Sheet dated 5/1/09 shows that R44 has an order for a Pureed Diet. It also lists diagnoses including, Alzheimers Dementia. The initial Speech Therapy assessment done on 10/27/08 indicates a diagnosis of Dysphagia; oral phase, and the need for speech therapy to work with the resident to manage the dysphagia, related to chewing difficulties. The Speech Therapist noted that R44 required cues to swallow his food and staff needed to offer drinks to assist resident in oral clearance. On 1/6/09 per telephone order, R44 was changed to a full pureed diet.</p> <p>The MDS (Minimum Data Set) dated 5/1/09 indicates R44 is moderately cognitively impaired and exhibits impulsive tendencies. It shows R44 requires moderate to extensive assistance with activities of daily living, including transfers. This MDS also indicates R44 has problems with chewing and requires supervision and set up assistance with meals.</p> <p>The Facilities "Food Guidelines for Dysphagia Pureed Diet" states under the area of Fruit, "no fruit, juices with pulp or lumps." Added on 7/8/09 by the dietary department, no mandarin oranges, apricots, oranges.</p> <p>The Resident Care Plan for R44, last updated on</p>	F9999			

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F9999	<p>Continued From page 54</p> <p>5/27/09 under the problem "Potential for altered nutrition related to a diagnosis of dementia and dysphagia", lists the following interventions; "serve recommended diet-consistency as ordered, and follow swallow precautions."</p> <p>The facility's Occurrence Reports of the 7/4/09 incident, were completed by E43 CNA (Certified Nurses Aide) supervising the dining room during the incident, E46 LPN, first person to initiate CPR, (cardio-pulmonary resuscitation), and E45 LPN, who called 911 and assisted with CPR.</p> <p>E43 indicated on the Occurrence Report that the incident began at 4:50 PM on 7/4/09. E43 notes that she was pouring beverages at 4:50 PM in the "Blue Dining Room." Dessert was set out on the tables by dietary staff before the residents were allowed to be seated. E43 was called over to the table where R44 was seated, and asked him a question. R44 did not respond. E43 lifted R44's head and noted "a piece of food coming out of his mouth. I checked his pulse, there was no pulse." E43 then ran to get help. E42 dietary aide, was in the hall outside the dining room, and E43 asked if she had seen the nurse because a resident was unresponsive. E42 replied that she had not. E43 located another CNA and told her to also go find the nurse. E43 ran down the hall, was unable to locate the nurse working her unit, but did locate E46 LPN, on 1 West, who ran down to the dining room to help.</p> <p>Per the Occurrence Report filed by E46, E46's participation began at 5:00 PM. When she arrived R44 was unresponsive. E46 did a finger sweep and retrieved a mandarin orange slice out of his mouth, then checked for a pulse. There was no pulse and no respiration. The staff put R44 on</p>	F9999			

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F9999	<p>Continued From page 55</p> <p>the floor and initiated Cardio-Pulmonary Resuscitation. E46 then asked E43 to check if R44 was a full code. E43 then ran back to the nurses station to check for the code status and retrieve the crash cart R44 was listed as a full code. E46 continued CPR until the paramedics arrived</p> <p>E45 LPN indicates by documentation that her involvement started at 5:00 PM when she was asked by E43 to call 911. She then joined E46 in the dining room to assist with CPR.</p> <p>Transcripts from the ambulance service care report document that emergency dispatch was notified at 5:14 PM, (twenty four minutes after R44 was found unresponsive). The ambulance arrived at the facility at 5:20 PM. The paramedics assumed care of the resident at 5:21 PM. Documentation shows pulse and respiration were absent upon their arrival, and upon intubation attempt they found the airway "full of small oranges," which required removal with long bent tipped forceps. The patient was then hyperventilated, given medications and his pulse resumed, but no spontaneous respiration. R44 arrived at the local hospital emergency room at approximately 5:52 PM.</p> <p>The emergency room report completed by Z10, emergency room Physician, and dated 7/4/09 states, "Attempts to suction the endotracheal tube were unsuccessful,"..... the material was unable to be suctioned out and the tube had to be removed. "Extensive efforts were made to clear the airway by myself using (long, bent tong) forceps and suction." R44 was re-intubated and transferred to Intensive Care. Radiology reports of the chest x-ray done in the emergency room</p>	F9999			

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F9999	<p>Continued From page 56</p> <p>showed, "Streaky opacities in the left lung which could indicate atelectasis, pneumonia or aspiration."</p> <p>R44 expired the next day in the Intensive Care Unit. The Discharge Summary dated 7/5/09 states "according to the nursing home staff, (R44) was sitting in the dining room eating oranges." Discharge Diagnoses include 1) Status Post Cardiopulmonary Arrest and aspiration of gastric contents 2) Coma due to cerebral anoxia complicating the above.</p> <p>The Certificate of Death for R44 indicates the cause of death to be 1) Anoxic Brain Injury 2) Foreign Body Airway Obstruction 3) Aspiration of Food Bolus.</p> <p>A) E43, CNA stated on 10/1/09 at 1:30PM that " (R44) was supposed to get pureed food, but somehow he got oranges. One of the ladies at the table called me over. I looked at (R44) and he was really pale. I saw a piece of orange fruit hanging out of his mouth. I couldn't get him to respond so I went to get my nurse. One of the dietary staff, (E42) was in the hall, I told her I was going to get help for (R44)."</p> <p>E42 Dietary Aide, stated on 10/1/09 at 11:05AM, " the kitchen staff puts out the desserts before the residents come in to the Blue Dining Room." On 7/4/09 E43 asked me if I saw a nurse in the hallway, I told her no. She told me a resident was unresponsive, and she was going to get help." I am not trained in CPR (cardiopulmonary resuscitation), but I did know how to feel for the pulse in the neck. I checked (R44) and I couldn't feel one, I wiped some food off of his face, but he felt cold."</p>	F9999			

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F9999	<p>Continued From page 57</p> <p>E 46, LPN, stated on 10/1/09 at 2:20PM that "(E43) came running down to 1 West, the hall I was working on that night. She stated she could not find her nurse and asked for my help in the dining room. When I got down there (R44) was out. I thought he had a heart attack, but I knew (R44) had a habit of gulping food and taking food off of other peoples plates at his table, so I did a finger sweep. I pulled out a mandarin orange....it was a whole piece. I checked his pulse and started CPR. When the paramedics got there they took over and tried to intubate him. They couldn't get the tube in because of food in his throat. They had to use forceps tongs to pull the food out before they could get the tube in."</p> <p>E45, LPN, stated on 10/1/09 at 10:20AM that E43 came running to get help and asked me to call 911. She stated a resident was unresponsive in the dining room and E46 was down there and needed help. "When I got down there I noticed (E46) had pulled pieces of mandarin oranges from (R44's) mouth. I had witnessed in the past that (R44) would sometimes take food from other residents plates, and gulp his food. When the Paramedics arrived they tried to intubate him but couldn't, they had to use forceps and go pretty deep. They pulled out more oranges." The next day the Physician from the hospital called back here to see what medications had been given during the code, and he asked if I knew what the orange stuff was that he ate, because they were still suctioning it out of him the next day."</p> <p>In the investigation statement given by R47, (a resident who eats in the same dining area, and was present on 7/4/09) to the Director of Nurses on 7/6/09, R47 stated, he "didn't notice anything</p>	F9999			

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F9999	<p>Continued From page 58</p> <p>wrong with (R44) but he liked to shovel his food in so maybe that is what happened."</p> <p>On 10/1/09 at 12:25 PM R45, who ate at the same dining table as R44, and was present for the incident on 7/4/09 stated, " I remember he was eating something round on a spoon, he started coughing quite a bit, then the girl came over and went for help. I have had to tell them once or twice before that he should not get regular food, to take it away because it was supposed to be pureed." R45 was assessed on 8/1/09, by the facility on her Minimum Data Set as having minimal cognitive difficulties, in new situations only, and no short or long term memory problems.</p> <p>On 10/1/09 at 12:35 PM R46, (who was also present on 7/4/09 and ate at the same dining table as R44) stated, "Everybody at the table got the same oranges that day. (R45) didn't want hers and pushed them to the middle of the table. I wondered why (R44) got oranges, he is supposed to have pulverized ones. He ate them, he was coughing a lot." R46 was assessed on 9/1/09, by the facility on her Minimum Data Set as having minimal cognitive difficulties in new situations only, and no short or long term memory problems.</p> <p>On 10 2/09 at 2:15 PM E44 , Dietary Manager stated, "there is a seating chart on the wall in the Blue Dining Room, and a book with the diet orders in it. People are supposed to check the seating chart and then the diet orders to make sure they get what they are supposed to get. We don't even serve mandarin oranges any more after what happened to (R44)."</p>	F9999			

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F9999	<p>Continued From page 59</p> <p>B) The Carle Arbours Policy titled "Cardio Pulmonary Resuscitation" last revised 7/24/99, states under the subtitle; "Personnel who may perform, ...One or more CNA'S from the resident hall/floor. Under the subtitle; Responsibilities of the Code 99 Team, #4) If certified, initiate CPR and stay with the resident until the code team arrives, or directed to do otherwise."</p> <p>The Carle Arbours, "Orientation Schedule", which is undated, and the "Orientation Skills Checklist" do not indicate that resident emergencies , CPR, or Choking are included in the new employee orientation schedule. On 10/2/09 at 2:30 PM E2 DON and E10 Staff Educator agreed that CPR, resident emergency response, the Heimlich Maneuver and use of the telephone system in an emergency were not a part of new employee orientation.</p> <p>Observation on 10/1/09 at 11:00 AM, of the Blue Dining room and the West, first floor dining room showed that both dining rooms had suction machines and intercom/phones available on site.</p> <p>On 10/1/09 at 1:30 PM, E43 CNA stated "It was a lot of back and forth running around. Afterwards one of the other CNAs asked me why I didn't use the phone in the dining room to call for help or page someone. I didn't even know to use them for emergencies. I should have been told to do that in orientation but they never told me that. It would have saved a lot of time."</p> <p>On 10/1/05 at 2:20 PM E46 LPN stated, "all of the running around to find help probably took about 10 minutes. I was upset about the way things went that day. That CNA didn't know what to do, never even tried a Heimlich maneuver or</p>	F9999			

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F9999	<p>Continued From page 60 anything. Things were so disorganized."</p> <p>On 10/2/09 between 11:00 AM and 12:00 PM the following Registered Nurse and Certified Nurses Aides were interviewed; E52 RN, E47 CNA, E48 CNA, E49 CNA, E50 CNA, E51 CNA, E53 CNA, E54 CNA, and E35 CNA. Of the above 9 employees interviewed none were able to state what was included in the Policy that addresses Cardiopulmonary resuscitation, emergency response or choking. Seven of the nine E47, E48, E49, E50, E51, E53, and E54 stated their first response to an arrest or choking incident would be to yell for a nurse or run to get help. This is despite the fact that E48, E49, E51 and E53 are all CPR certified to initiate CPR/Heimlich. Of the 9 employees interviewed three E50, E51, and E54 were not aware of the telephones in the dining rooms and how to use them in an emergency. Six employees E50, E51, E54, E47, E48 and E35 stated that the use of the telephones to page for help in an emergency, the emergency response policy, CPR and the Heimlich maneuver were never covered in new employee orientation.</p> <p>On 10/6/09 at 1:30 PM Z10, the Emergency Room Physician that treated R44 stated, "I would expect anyone in a medical situation to be informed of the basic life support systems and know how to rapidly access EMS (emergency medical systems). It sounds like that did not occur in this case-there was a delay. At the very least proper airway management/positioning and getting help more quickly would have helped and should be expected."</p> <p>(A)</p>	F9999			

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F9999	Continued From page 61 Validation Survey for Subpart U: Alzheimer Unit 300.7050c) 300.7050d) 300.7050f) Section 300.7050 Staffing 300.7050c) All staff who ever work on the unit (e.g., nurses, CNAs, housekeepers, social services and activities staff, and food service staff) shall receive at least four hours of dementia-specific orientation within the first 7 days of working on the unit. This orientation shall include: 1) Basic information about the nature, progression, and management of Alzheimer's disease and other dementia; 2) Techniques for creating an environment that minimizes challenging behavior from residents with Alzheimer's disease and other dementia; 3) Methods of identifying and minimizing safety risks to residents with Alzheimer's disease and other dementia; and 4) Techniques for successful communication with individuals with Alzheimer's disease and other dementia. 300.7050d) Nurses, CNAs, and social service and activities staff who work on the unit at least 50 percent of the time that they work at the facility shall participate in a minimum of 12 additional hours of orientation within the first 45 days after employment, specifically related to the care of persons with Alzheimer's disease and other dementia. This orientation shall be defined in	F9999			

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F9999	<p>Continued From page 62</p> <p>facility policies and procedures; shall be in a form of classroom, return demonstration, and mentoring; and shall define to new staff the elements contained in Section 300.750(e)(1)-(10).</p> <p>300.7050f) Within 6 months after January 1, 2005, or within 6 months after hire, the facility administrator and director of nursing shall attend the orientation for staff who work on the unit at least 50 percent of the time in accordance with subsection (d).</p> <p>These requirements are not met as evidence by:</p> <p>Based on record review and interview, the facility failed to provided the required staff training for 5 out of 10 staff reviewed, who work on the specialized Alzheimer"s unit.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. On 9/24/09 at 11:10 a.m. E13, Unit Director of the specialized Alzheimer's unit stated E1, Administrator, started employment on 2/2/09 and as of date had only completed the 4 hour basic Alzheimer's and related dementia training. E1 has not received the additional 12 hours, which should have been completed by 8/09. 2. On 9/24/09 at 9:30 a.m. E13 stated she started employment on the specialized Alzheimer's Unit as Unit Director on 2/2/09. E13 did not complete the 4 hours of basic training within the 7 day timeframe. Educational documentation shows E13 completed the 4 hour basic training and an additional 8 hours of Advance Topics in Alzheimer's Care on 6/17/09. E13 has not completed the 12 additional hours of 	F9999			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/08/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145439	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/06/2009
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F9999	<p>Continued From page 63</p> <p>education required within the first 45 days of employment. This was confirmed by E13 on 9/24/09. E13 stated she is currently responsible for the ongoing staff training on the unit.</p> <p>3. Educational documentation shows E21, Certified Nurse Assistant (CNA) completed the 4 hour basic training on 1/9/09. On 9/24/09 at 9:30 a.m. E13 stated E21 started working on the unit on 1/12/09 in a full time capacity. E13 stated E21 has not completed the additional 12 hours of education that is required within the first 45 days.</p> <p>4. On 9/24/09 at 9:30 a.m. E13 stated E20, CNA, started working on the unit one month ago, and works less that 50 percent of her time on the unit. E13 was unable to provide the date that E20 was first assigned to the unit or of the date E20 completed the 4 hour basic training.</p> <p>5. Educational documentation shows E22, CNA, works full time on the night shift and has completed the basic 4 hour training on 7/7/09. On 9/24/09 at 9:30 a.m. E13 stated that E22 started on the Alzheimer's unit on 6/1/09 and works full time on the unit. E13 stated E22 has not received the additional 12 hours of education due within the first 45 days of employment.</p> <p>E20 and E21 were two of the three day shift CNAs providing care on the Alzheimer's Unit on 9/22/09.</p> <p style="text-align: center;">(B)</p>	F9999			